Alberta Health Services

Glenrose Rehabilitation Hospital

# Adult FASD Assessment Clinic

**Fetal Alcohol Spectrum Disorders (FASD) is a term that includes all of the diagnoses/difficulties that individuals may have if they were exposed to alcohol prenatally (in the womb). These difficulties may involve problems with thinking, behavior, and emotional functioning.**

*As one of Canada's premier rehabilitation facilities, the Glenrose Rehabilitation Hospital offers specialized inpatient and outpatient programs for children and adults. Through the special skills of our physicians and staff, it is a place where patients and their families meet the challenges of disability and seek to improve their physical, mental, and spiritual health. Established in 1964, the Glenrose continues as a leader in geriatric and rehabilitation research, technology, education and rehabilitation programs for residents of Northern and Central Alberta and beyond.*

The Adult FASD Assessment Clinic is funded by the Edmonton Fetal Alcohol Network Society and is administered through Alberta Health Services

## Who is the Clinic for?

The Adult FASD Assessment Clinic is for adults from the Edmonton area, who are experiencing difficulties that are suspected to be the result of prenatal alcohol exposure. These individuals may have difficulty with education, employment, and independent living.

- Confirmation of prenatal alcohol exposure will be needed before the assessment can take place. The clinic coordinator can assist with this.

## How can an individual access the clinic? Who can refer?

A referral is needed.

Mentors or advocates that are from an agency or service associated with the Edmonton Fetal Alcohol Network Society (EFAN) can refer their clients for an assessment

- The mentors or advocates will serve as the primary contact. They must be able to support their clients throughout the assessment process and be able to provide follow-up.

Health care and other professionals can refer however the individual will require a mentor/advocate/support person or representative to assist throughout the assessment process.

* The intent of the Mentor / Advocate / Representative is to ensure the client is provided the best opportunity to apply the recommendations resulting from the assessment to their life.

## Who is involved?

The assessment team includes a Coordinator, a Neuropsychologist, a Psychometrist, a Registered Nurse, and a Social Worker. During the assessment process the team will work with clients, their mentors or advocates, and any other support people that they would like to involve in their assessment. This could include family members, close personal friends, and any professionals or service providers they may be working with.

**Assessments are conducted according to the University of Washington FAS Diagnostic & Prevention Network (FAS DPN) model and the FASD Canadian Guidelines for Diagnosis.**

## How long does the assessment take?

The assessment team will need to access birth, health, and education records as well as other relevant documents such as adoption, mental health, and social service records. Consent will need to be provided by clients for these records to be obtained. It may take up to three months (or longer) for the records to be received. When all of the records and required documentation are received, the mentors or advocates will be contacted to schedule an appointment.

The assessment will consist of at least three sessions. More time may also be required for consultation with a physician or other health care professionals before a diagnosis can be made.

## What happens in the assessment process?

Clients and their family members or caregivers will be interviewed and asked to fill out some questionnaires. Clients will complete about six hours of testing to look at their thinking skills. The assessment will also include a brief health screen, and the nurse will take pictures to look at facial features that are sometimes seen in individuals with prenatal alcohol exposure. The clinic will consult with family physicians (whenever possible) and other specialists as needed to assess for any past or current medical concerns that could impact the assessment.

## How will the results of the assessment be provided?

Clients may or may not receive an FASD diagnosis; however, the results of the assessment will be shared with them, their mentors or advocates and anyone else they choose to include. Clients (and their support people) will have an opportunity to learn about their strengths and areas of difficulty. A management plan to address their current needs will be developed and will include linkage to services and supports. The Mentor / Advocate / Representative will help with the implementation of the management plan.

**For additional information contact:**

**Ph:** **780-735-6166**
**Fax:** **780-413-4979**

**Address:**
Adult FASD Assessment Clinic
Glenrose Rehabilitation Hospital
10230 – 111 Ave
Edmonton, AB T5G 0B7

www.albertahealthservices.ca
www.edmontonfetalalcoholnetwork.org
www.fasd.alberta.ca

Alberta Health Services

**Adult FASD Assessment Clinic**
**Glenrose Rehabilitation Hospital (GRH)**

# Intake Package

**To:** Attention: **Coordinator, Adult FASD Assessment Clinic**
FAX: **780-413-4979**

**From:** Client Name: _____

Alberta Health Care Insurance #: _____

DOB: _____ Age: ____

Phone #: hm: _____ cell: _____

Address: _____

_____

_____

I would like to receive an assessment for Fetal Alcohol Spectrum Disorder (FASD) and

_____ with _____ Ph: _____
*Representative/Advocate/Mentor* *Agency*

has agreed to act as my representative and will assist me throughout the assessment process.

The following are attached:

- ☐ Referral form/letter
- ☐ Client Information checklist
- ☐ Consent for representation
- ☐ AHS Consent to Disclose Health Information
- ☐ Other (please indicate) _____

_____ _____
Client's Signature Date

_____ _____
Representative/ Advocate/ Mentor Date

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Clinic : 780-735-6167
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Alberta Health Services

**Adult FASD Assessment Clinic**
**Glenrose Rehabilitation Hospital (GRH)**

# Referral

**To:** Attention: **Coordinator, Adult FASD Assessment Clinic**
FAX: **780-413-4979**

**From:** Name: _____

Agency: _____

Program: _____

Phone #: _____ cell#: _____ FAX#: _____

Address: _____

_____

_____

**Re: Referral to the GRH, Adult FASD Assessment Clinic**

On behalf of _____ please accept this referral to the
*Client Name*

Adult FASD Assessment Clinic.

Referral letter attached _____ or Rationale provided below for the referral _____

_____

_____

_____

_____

_____

_____

_____

Intake Forms are attached _____ or Please provide intake forms _____

_____ _____
Signature Date

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# Consent for Representation

I, _____ consent to have an assessment for Fetal Alcohol Spectrum
*Client Name*

Disorder (FASD ). I grant permission for my _____
*Advocate/Mentor/Representative*

from _____ at _____ to serve as my
*Agency Name* *Phone Number*

representative and support person throughout my involvement with the Adult FASD Assessment Clinic. This role includes serving as the primary contact person, arranging my appointments, and assisting me with the management plan.

_____ _____
Client's Signature Date

# Acknowledgement of Representation

I, _____ agree to serve as the
*Advocate/Mentor/Representative*

representative for _____ throughout the Adult
*Client Name*

FASD Assessment Clinic process. I recognize that accepting the role of representative includes the following responsibilities: arranging my client's appointments, supporting my client throughout the assessment process, and assisting my client with their management plan.

_____ _____
Representative's Signature Date

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# Client Information Checklist

**(Please read and check the boxes)**

I, _____, understand that by agreeing to participate in
*Client Name*
a Fetal Alcohol Spectrum Disorder (FASD) assessment:

- ☐ The FASD assessment team will seek confirmation that I was exposed to alcohol prenatally (in the womb).
- ☐ I will be involved in the assessment process, which may require three or more appointments.
- ☐ My medical, school, legal, and mental health records will be reviewed by the Adult FASD Assessment team.
- ☐ I may have to see another health care provider before I receive a diagnosis.
- ☐ I may not receive an FASD diagnosis.
- ☐ I will be provided with the opportunity to learn about my strengths and areas of difficulty.
- ☐ I will receive a management plan that will help me access the appropriate services in order to address my needs.

_____ _____

Client's Signature Date

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| Name *(last, first)* | | |
|---|---|---|
| Birthdate *(yyyy-Mon-dd)* | | |
| PHN# | HRN# | CoMIS# |

Alberta Health Services

## Consent to Disclose Health Information

The patient/client or his/her authorized representative must complete this form before AHS may disclose the patient's/client's health information to someone else *(unless Alberta's Health Information Act authorizes disclosure without consent)*. The information of this form, together with any records authorizing a representative to act on behalf of the patient/client, is being collected under part 3 of the Health Information Act for the purpose of recording the patient's/client's consent to the specified disclosure and will be filed on the patient/client record. For questions about this collection of information, contact the program area that provided you this form or contact the Chief Privacy Officer at 10301 Southport Lane SW, Calgary AB T2W 1S7 or call 1.877.476.9874.

| **Patient/Client Name** * | | | |
|---|---|---|---|
| **Date of Birth** *(yyyy-Mon-dd)* * | **Personal health number** *(authorized by HIA s.21(1))* * | | |
| **Address** * | **City/Town** * | **Province** | **Postal Code** |

Details of health information being disclosed *(write in full without abbreviations, include dates of treatment)*
***Medical, functional, and social information needed*** *to allow the Advocate/Mentor/Representative to provide assistance through the pre, mid, and post Adult FASD Assessment Clinical process. This includes attendance at the "Debriefing/Management Planning" Conference.*

Identify below where records exist **(GRH Adult FASD Assessment Clinic is releasing information to the Mentor/Advocate/Representative for their participation in the client's assessment process)**

| Health service provider, hospital, clinic program | City/Town |
|---|---|
| *Adult FASD Assessment Clinic, Glenrose Rehabilitation Hospital* | Edmonton |
| **Date of consent is effective** *(yyyy-Mon-dd)* * | Expiry date *(valid for 2 years if no date)* *(yyyy-Mon-dd)* |

Name of individual(s)/organization(s) information is being disclosed to
***NAME of Agency, Program, and contact information for the Mentor/Advocate/Representative (or assigned Mentor/Advocate/Representative) -***

| **Phone** * | **Address** | **City/Town** | **Province** | **Postal Code** |
|---|---|---|---|---|
| | | | | |

Purpose(s) of disclosure
***To allow the Agency Advocate/Mentor/Representative to assist the patient/client throughout the Adult FASD Assessment Clinic process (pre, mid and post assessment).***

**Authority of person(s) giving consent** *(If signing on behalf of the patient/client, indicate your authority below and provide a copy of the document which authorizes you)*

- ☐ **Guardian (or Trustee)** - of a minor under the age of 18 years, who is not determined to be a mature minor
  - named in a Guardianship Order/appointed under the Adult Guardianship and Trusteeship Act, if access to health information relates to the power and duties of the guardian (or trustee)
- ☐ **Nearest relative under Mental Health Act** - if access to health information is necessary to carry out obligations of the nearest relative
- ☐ **Agent** - appointed in an enacted personal directive according to the Personal Directives Act
- ☐ **Personal representative** - of a deceased patient, if the access to information relates to administration of the individual's estate
- ☐ **Power of attorney** - if access to health information relates to the powers and duties of the attorney
- ☐ **Written authorization** - any written authorization from the individual to act on the individual's behalf
- ☐ **Specific decision maker** - as defined in the Adult Guardianship and Trusteeship Act

I authorize AHS to disclose the health information described above to the individual(s) or organization(s) indentified above. I understand why I have been asked to disclose my individually indentifying information. I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my health information. I understand that I may revoke this consent in writing at any time.

| **Name of person giving consent** * | **Signature** * | **Date** *(yyyy-Mon-dd)* * |
|---|---|---|
| | | |